

Case report

Eighteen needles to forget...an unnamed past

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Abstract

Lasthénie de Ferjol syndrome is a very rare psychiatric illness that occurs mainly in women. It is characterized by severe recurrent iron-deficiency anemia caused by repeated episodes of self-induced blood-letting. We report the case of a young homosexual male repeatedly admitted to various hospitals for severe hypochromic anemia. We discovered that the anemia was indeed due to psychotic self-provoked hemorrhages. Based on this experience and a review of the few cases reported in the literature, we discuss issues of early diagnosis, management and treatment of Lasthénie de Ferjol patients.

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Keywords: Anemia; Microcytic anemia; Self-induced blood-letting; Factitious disorder; Lasthenie de Ferjol syndrome; Psychotherapy**1. Introduction**

Lasthénie de Ferjol syndrome is a very rare psychiatric pathology characterized by severe relapsing anemia due to repeated self-induced hemorrhages. To our knowledge, only cases have been reported in the medical literature. Somatic therapy is fundamental but palliative. Psychotherapy is the most useful approach, and it should begin as

soon as possible to prevent the illness from becoming chronic or even lethal. We report the case of a young homosexual male with Lasthénie de Ferjol syndrome, who was diagnosed by our staff after he had been engaged in self-induced blood-letting for three years.

2. Case report

A 29-year-old man from a small town in central Sicily was admitted to the Internal Medicine Department of University of Catania because of profound asthenia,

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palpitations, and dyspnea after very moderate effort. Over the past three years, he had been repeatedly admitted to various hospitals for severe anemia. The most recent hospitalization had ended a month before our observation. He had been discharged with diagnoses of hypochromic anemia, hiatal hernia with reflux gastritis, and chronic inactive hepatitis B. Iron, vitamin B12, and folic acid had been prescribed, but the patient admitted that his compliance had been poor. The remainder of the medical history was unremarkable. The patient lived alone, was currently unemployed, and denied use of tobacco, drugs, and alcohol. His parents were both alive although his father, an alcoholic, was suffering from tuberculosis. His six brothers and four sisters were all apparently healthy.

The patient's skin and mucosae were extremely pale and dehydrated. Subcutaneous fat was reduced, and there was no evidence of jaundice or edema. Examination of the chest, abdomen, and urogenital apparatus was unremarkable. Cardiovascular evaluation revealed a BP of 100/75 mmHg; HR 100 B/min; and a faint systolic murmur (Levine class II/VI) that radiated to all auscultation sites. Emergency lab work revealed hypochromic, microcytic, iron-deficiency anemia (RBC 2,400,000/mm³, Hb 4.5 g/dL, Hct 13.7%, MCV 57 μ L, iron 22 μ g/ml), serum ferritin 10 ng/ml, and cholinesterase 1920 IU/L. Hepatitis B markers indicated an asymptomatic carrier state (positivity for HBsAg and HBcAb). Serum glucose, BUN, creatinine, and serum electrolytes were within normal limits. Chest radiography was unremarkable. There was no evidence of hemoglobinopathy, and multiple stool specimens were negative for occult blood.

The patient was immediately started on fluid replacement therapy (2 L of normal saline) and transfused with packed red cells (two unities). Therapy was then continued with intravenous iron, folic acid *per os*, and vitamin B12 IM. After two days, the hemoglobin level had increased to 8 g/dL, and the RBC count was 3,270,000/mm³.

On the tenth day of hospitalization, during a conversation with the internist in charge of his case, the patient confided that he frequently indulged in self-induced blood letting, removing more than a liter of blood each time. The last such episode had reportedly occurred two weeks before his admission to our department. A psychiatric consultation was immediately requested. The patient was found to be alert, cooperative, and fully oriented with no signs of idea or perception disorders. He admitted to being homosexual and reported a very close relationship with his mother. His leaving home had been prompted by feelings of frustration and low-self esteem over his inability to protect her (and his younger siblings) from his father's physically violent behavior during his frequent bouts of drunkenness. There was no evidence of abnormal sleeping habits or eating disorder.

The self-injurious behavior was initially interpreted as depression-related, but after a month-long trial on antidepressant therapy (paroxetine), during which the blood-letting resumed, the diagnosis was revised. The patient was

felt to be suffering from the factitious disorder known as Lasthénie de Ferjol syndrome. He was discharged on psychotherapy with outpatient follow-up. Nine months later, a routine checkup revealed no evidence of anemia. He told us that, with the help of psychotherapy, he had improved considerably and no longer indulged in blood-letting. Indeed, he appeared much more self-confident than he had during the previous admission. Unfortunately, three months later, the patient abruptly interrupted therapy and has not been heard from since then.

3. Discussion

Lasthénie de Ferjol (LdF) syndrome is a rare psychiatric disorder characterized by severe and relapsing anemia secondary to repeated self-inflicted hemorrhages.¹ It was named² after the heroine of a Barbey D'Aurevilly novel, who bled to death after piercing herself with eighteen needles to expiate the "sins" of her rape and pregnancy.^{3,4} The syndrome is presently classified by the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*⁵ as a factitious disorder. Conditions of this type are characterized by dramatic, incoherent, and poorly documented histories. The symptoms are unusual, and they develop only when the patient is alone and unsupervised. They usually worsen during therapy, and relapses after an initial period of improvement are common. Patients with factitious illnesses "need to be sick," and they are constantly in search of new hospital admissions and/or medical examinations. They have trouble relating to people and, like our patient, they are often unemployed.¹ LdF syndrome seems to be an exception in that most patients reported thus far are females who work in medical settings.⁶ One of the hallmarks of factitious illnesses is, in fact, an impressive knowledge medical terminology. Patients with these disorders are usually very anxious, but do not like their relatives to be present, especially during history collection. For this reason, the true etiology of the illness is very difficult to diagnose, and the prognosis is usually poor.

The microcytic anemia observed in a patient with LF syndrome is non-specific, reflecting only chronic blood loss. Serum iron and ferritin values are very low whereas the total iron-binding capacity is elevated, so the most common diagnosis is iron-deficiency anemia. The work-up is negative for gynecological or gastrointestinal bleeding and nutritional deficiencies. The anemia improves when treatment is started, but the patients almost inevitably interrupt therapy and resume their blood-letting sessions. Surprisingly, despite their severe debilitation, most LdF syndrome patients continue to fulfill their professional and social duties. They appear highly cooperative and willingly submit to even the most invasive diagnostic procedures – until they realize that the true cause of their symptoms is about to be discovered. The diagnosis is based on the findings of anemia together with a singular psychological history.⁷

The blood-letting indulged in by LF syndrome patients is a regular and sometimes ritualized practice, an obsessive act that often serves as atonement for sexual “perversity”.^{8,9} In extreme cases, phenomena of “autovampirism” have been described.¹⁰ The methods used to provoke blood loss vary widely from one patient to another and include venipuncture with syringe aspiration (which was used by our patient), self-inflicted bladder or vaginal trauma, and, in rare cases, repeated blood donations in different centers.¹¹ The same patient may also use different techniques to avoid being discovered.

Somatic therapy based on blood transfusions and iron (IV, IM, per os) and vitamin supplementation is palliative. Psychotherapy¹² is fundamental, but it is inevitably a long and difficult process, and to be effective, it must be started shortly after the first symptoms appear. When the true nature of the blood loss has been identified, the physician should avoid revealing the discovery abruptly to the patient. The feeling of exposure often leads the patient to break off all relations with the physicians that have diagnosed the real problem and move on to another hospital or outpatient clinic.

Internists and hematologists who see these patients are generally unaware of the ongoing nature of the illness. Without psychiatric therapy, somatic treatment of the patient’s anemia is destined to fail. The patient rarely confesses to self-inflicted blood loss, so it is extremely important for physicians to obtain a complete medical history. Evidence of multiple relapses (particularly in a patient with features suggestive of factitious illness) should raise the suspicion of this syndrome, which is admittedly rare but frequently carries a negative prognosis. A psychiatric consultation should be arranged as soon as possible.

In LdF the doctor–patient relationship is frequently altered. The characteristic sense of alliance is often absent, and there may be strong antagonism between the internist, the hematologist, the psychiatrist and/or psychologist and the patient. As a result, it is very difficult to carry out an effective therapy.¹³

The goal of psychotherapy is to modify the patient’s thought-systems and behavior. Behavioral and systemic-relational (family) therapy can both be effective.¹⁴ Pharmacotherapy is generally not advised although some authors indicate that pimozide¹⁵ or serotonin reuptake inhibitors¹⁶ may be of benefit. In most cases, however, the results of drug therapy are very poor. Relapses are extremely common and death is often the outcome. The psychopathology is a cryptic “cry for help”,¹⁷ and the patient must be encouraged to use simpler more direct means to express feelings and needs.¹⁸ Once this communication channel has been established, the patient’s real problems can be faced and possibly resolved. Identification and treatment of possible co-morbidity (alcohol abuse, drug abuse, depression) is also an important part of therapy.¹³ Factitious illnesses and self-injurious behaviors may also be associated with eating disorders.^{19–21}

In conclusion, the Lasthénie de Ferjol syndrome should always be considered in patients presenting with recurrent unexplained anemia. Patients with this syndrome frequently end up on general medical wards under the care of internists or hematologists, but a psychiatric work-up should be arranged as soon as the possibility of factitious blood-letting is suspected.

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